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(For roster of County Society offices, see last month's issue)

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## New Clue to Cause of Lupus Erythematosus Found

The outlook for lupus erythematosus, a disease long considered to be very serious and nearly always fatal, is not so bleak after all, two Detroit physicians have stated.

Reporting a study of 100 cases in the current issue of the *Journal of the American Medical Association*, Drs. Clarence E. Rupe and Stewart N. Nickel, Henry Ford Hospital, said the disease is more benign than previously suspected. They also offered a clue to the possible cause of the disease.

Lupus erythematosus, also called LE, was once considered to be only a skin disease, because of its typical butterfly pattern of rash across the bridge of the nose. However, it is a systemic disease, affecting the joints and such organs as the liver and kidneys.

Treatment with artificial hormones, such as those used for arthritis, has a beneficial effect on the disease process by slowing it down and by carrying the patient through crises which once would have been fatal.

The benign course of the disease was illustrated by the fact that only 2 per cent of the total group "proceeded to incapacity," the physicians said. In addition, more than half of the men remained in good health and at full capacity. Fifty of the patients survived the disease at least 10 years after the onset, and 45 of these are still living. Duration of the disease ranged from 10 months to 36 years.

The clue to a possible cause of the disease lies in the fact that many of the patients had streptococcic infections just prior to the onset of LE. Many had typical "strep throat" infections, while others had other streptococcic infections, such as boils or ear infections. This suggests that hypersensitivity to the streptococcus bacillus may be an important factor in the disease, the physicians said, adding that this association may eventually produce a means of prevention.

## Urologist's "Know-How" Aids Surgical Patients

A conscientious physician came to the aid of the thousands of patients who suffer from the common and distressing condition of urinary retention after surgery.

He is Dr. Myron H. Nourse, a urologist, from Indianapolis.

Dr. Nourse studied the problem, backed up his own findings with the results of a questionnaire which he personally mailed to 151 members of the American Urological Association, and concluded it was time "to organize our thoughts on this subject."

Writing in the *Journal of the American Medical Association*, Dr. Nourse said that the problems associated with this condition, which so many surgical patients dread, exist largely "because of increased numbers of patients hospitalized and decreased numbers of trained professional help."

Patients unable to void after surgery, in spite of a full bladder, normal kidney function, and the absence of any organic obstruction, usually undergo catheterization.

"Is this procedure really necessary?" Dr. Nourse asked. He said that while the answer must come only from the doctor in charge, his associate, or his assistant, consideration had to be given to many other complex factors, including the type of patient.

(Continued on Page 24)



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## Urologist's "Know-How" Aids Surgical Patients

(Continued from Page 22)

He urged doctors not to write out catheterization orders too freely, but to give more realistic personal attention and supervision to the patient.

"Leaving routine postoperative catheterization orders to the interpretation and discretion of the nursing service is a practice to be discouraged," Dr. Nourse said in his article.

"Changing trends exist in hospitals today with regard to patient care," he said. "Personal attention to patients' simple wants and needs is often lacking. It is thought to be somewhat 'old-fashioned' to request that a considerate attitude be displayed. For example, many patients could urinate spontaneously after operation if the urinal were present and within reach. Adequate personal preoperative and postoperative instruction to the patient lends confidence and mental tranquility of a degree far superior to that effected by tranquilizing agents."

"Real bedside nursing has also become 'old-fashioned' and is for practical purposes a 'lost art,'" he said, adding: "Many tasks, including catheterization, are relegated to nonprofessional nursing help and the new graduate soon finds she has much to learn before she can become a good nurse."

He said that catheterization is not without danger and that despite the most careful technique, infec-

(Continued on Page 40)

## Persons Over 40 Need Glaucoma Examinations

Examination for glaucoma, which may lead to blindness, should be an "indispensable" part of all physical examinations of persons over 40 years, five Memphis physicians have stated.

Persons with chronic diseases, such as hardening of the arteries, high blood pressure or arthritis, especially should be examined for the disease, the physicians said in the October 24 issue of the *Journal of the American Medical Association.*

In glaucoma, which is most prevalent in persons past 40 years of age, tension within the eyeball is increased. The structure contains fluid that keeps the orb from collapsing. The fluid enters through openings in one part of the eye and escapes from others. Glaucoma occurs when the outflow is blocked and the excess fluid builds pressure in the eyeball and damages the nerve cells.

It can be treated and blindness prevented if the disease is discovered early enough. A simple test, tonometry, can show the presence of glaucoma.

The physicians reported a study of 13,155 persons in hospital and nonhospital groups during a two-year period. Tonometer testing revealed 271 cases of subclinical glaucoma not under treatment. During the same period 62 persons who visited the ophthalmology clinic at the teaching hospital of the University of Tennessee College of Medicine were found to have the disease.

The highest rate of glaucoma was found in residents of a home for the aged, where 6.4 per cent of those examined had the disease. The next highest rate (3.4 per cent) was in Negro women visiting outpatient clinics and in Negro males engaged in occupations involving considerable manual labor (3.1 per cent).

(Continued on Page 40)

## Points Up Early Signs of Multiple Sclerosis

The nation's general practitioners were urged to be on the lookout for early signs of multiple sclerosis when their patients pay them an office visit.

Multiple sclerosis, commonly called MS, is a tricky disease" to diagnose, and a Duxbury, Mass., physician, writing in the *Journal of the American Medical Association,* outlined a number of practical hints that may alert the general practitioner to recognize the condition in its early stages.

MS usually involves a "hit-or-miss" pattern and is likened to syphilis, which can imitate any disease.

"I have found," said the author, Dr. Walter E. Deacon, "that, clinically, certain signs and symptoms seem to be more prominent than one would expect from a 'hit-or-miss' pattern."

Dr. Deacon offered the hypothetical case of a patient who walked into a doctor's office and complained of sore throat or an upper respiratory infection. The patient is treated, but returns two or three weeks later, complaining of numbness or weakness of an arm or a leg or of visual blurring.

He said that many physicians might "dismiss the episode with a wave of the arm," but actually these

(Continued on Page 48)

## Urologist's "Know-How" Aids Surgical Patients

(Continued from Page 24)

tion of the bladder may follow. He cited this as another reason why catheterization should be in experienced hands.

Dr. Nourse said that preoperative and postoperative discussion between doctor and patient was, in his opinion, the best way to help the patient with this distressing problem. Such discussions and suggestions with 2,000 patients, he said, lowered the percentage of those who had to be catheterized from 18.3 to 1.7.

## Persons Over 40 Need Glaucoma Examinations

(Continued from Page 36)

The lowest rate was in white women who engaged in occupations requiring "discriminatory visual activity," such as teaching or department store clerking. Their low rate may result from the fact that they have frequent eye examinations and glaucoma is discovered early.

In general the study produced three conclusions: glaucoma occurs more frequently as age increases; it occurs more frequently in Negroes than in white persons, and there seems to be an association between the disease and other chronic diseases, such as arthritis or high blood pressure.

The authors are Drs. Henry Packer, Alice R. Deutsch, Philip M. Lewis, Claude D. Oglesby, and A. C. Cheij.

## Points Up Early Signs of Multiple Sclerosis

(Continued from Page 40)

symptoms could be "the initial onslaught of multiple sclerosis in certain susceptible persons." A careful follow-up examination, especially if the symptoms recur, may reveal changes in reflexes or some muscular atrophy or weakness, he said.

Dr. Deacon urged practicing physicians to be more patient with neurotics who have a multiplicity of such complaints as aches, pains, weakness, inability to cope with everyday chores and dizziness.

For some unknown reason, he said, these people are particularly susceptible to MS. "Usually the patient has visited every physician within a radius of 50 miles. . . . A carefully taken history, however, may reveal a multiplicity of neurological complaints and a careful examination may reveal changes sufficient to warrant a guarded diagnosis of MS."

Dr. Deacon stated that frequently early signs and symptoms of MS show up during pregnancy which is considered a stress state, both mentally and physically. He said that in his own practice he has seen three cases in 16 in which MS first developed during pregnancy.

Dr. Deacon urged all physicians who practice obstetrics to include a careful neurological examination as a part of their general physical examination in order to uncover mild or incipient MS.

"A group of neuromuscular defects are so obviously due to disorders of the central nervous system that a glance at the patient determines that further appraisal and referral is necessary," the Massachusetts doctor said in his article, adding: "These include scanning speech, tremor, obvious dragging of a leg or a wasted arm, and marked gait difficulties."

He said that these defects reflect "the insidious, mild, and transient attacks which escape detection unless the physician is alerted to the possibility of MS and a careful follow-up is performed periodically."

## 6,860 Students Receive M.D. Degrees in 1958-59

In its annual comprehensive report on all aspects of medical education, the Council on Medical Education and Hospitals of the American Medical Association announced that the 1958-59 graduating class receiving the M.D. degree numbered 6,860, only one less than in 1957-58.

These two classes were the largest except for the 1954-55 year when the class was 6,977. The increase in that term was occasioned by including as graduates the 50 students completing the intern year then required by Stanford University.

According to the council's report, which appeared in the Nov. 14 issue of the *Journal of the American Medical Association*, 43 medical schools had decreases in the number graduated while 34 schools experienced increases.

Women comprised 5.4 per cent of the graduating class and comprised 5.9 per cent of the Canadian 1958-59 graduating class.

Much of the council's report dealt with educational opportunities for the number of medical students considered adequate to satisfy medical service needs in a vastly growing population.

"To accomplish this task and at the same time maintain high standards of medical education repre-

(Continued in Back Advertising Section, Page 60)

California MEDICINE

OFFICIAL JOURNAL OF THE CALIFORNIA MEDICAL ASSOCIATION

VOLUME 92 JANUARY 1960 Number 1

# Medicine at Mid-Century

**T. ERIC REYNOLDS, *M.D.*, Oakland**
***President, California Medical Association***

IT IS A PRIVILEGE to live in the mid-20th century and to have witnessed the great changes as they have unfolded. I feel especially lucky to have lived as a United States citizen during this time—perhaps no people in man's history have been more fortunate. Without attempting the role of social philosopher, I should like to record some observations, just as a physician along the way, and suggest a few deductions that might be made from them. It may well be that too many physicians are so busy with the practice of medicine that they never take time to think about it.

Physicians and friends of medicine often ponder the curious antipathy of certain segments of society to medical practice. Why is it that a highly trained and lengthily educated profession, notable for self-discipline, is so frequently assailed in conversation and in the press?

To explain this anomaly, some go so far as to say it is a part of a gigantic conspiracy to overthrow and discredit private enterprise and usher in the complete socialist state. I doubt this, although I have recently heard members of Congress state that they thought it was a socialist conspiracy. In any case, the mistrust of medicine is widespread, and, at times, a little mystifying. How can it be—we ask—that a professional group which strives to promote medical progress through research, which places no limit upon its own services, which contributes so much of its time without remuneration, can be condemned as commercial, or even mercenary? What about the endless phone calls any time of day or night, the notes to schools, employers, jury commissioners, the medical history résumés to other doctors, the conferences with relatives, none of them services that carry a price tag? Are such services not appreciated? Can it be the "bad apple in the barrel" that brings about the condemnation of a whole profession? Or can it have been the evolutionary development of our present economic climate, including the medical insurance device, that has altered the public image of the practicing physician?

Perhaps it might help to examine the question in historical perspective, to see medicine as it is—not necessarily as we might wish it to be—as an integral part of a vast and revolutionary development which has already altered our political and economic environment to an extent perhaps inconceivable at the turn of the century.

Those of us here today are witnesses to not one but several major revolutions, on a world-wide scale. Social changes have occurred in the past century more far-reaching than any in the history of man. In medicine, specifically, concepts and procedures have changed more in the past 75 years than in the period of 5,000 years preceding them. Ours is a time of flux and excitement, and, as was said by Dr. Edwin L. Crosby, director of the American Hospital Association, quoting a friend of his: "It is exciting to live in a time of revolution. It is tragic not to realize it."

Let me elaborate. In only a few years we have wit-

An address before the annual Western Conference of Medical Care Plans, November 8 to 12, 1959, Honolulu.

California MEDICINE

For information on preparation of manuscript, see advertising page 2



# EDITORIAL

## A Study of C.M.A. Scientific and Educational Functions

WHEN Heller Associates was hired to make an investigation of the organizational structure of the California Medical Association some time ago, its main concern was with administrative structure and efficiency. This firm of experts in matters of business procedures was admittedly not equipped to make a study or recommendations with regard to what we must look upon as the very soul of our state medical association—our constitutional pledge "to promote the science and art of medicine, the protection of public health, and the betterment of the medical profession." These are matters with which the scientific and educational functions of the association are vitally intimate.

It behooves an organization whose scientific meetings are now no better attended than they were when the membership was half the present number, to look into the reasons for this apparent symptom of failure in a cardinal service.

Recently, recognizing that what the California Medical Association does now in its scientific and educational activities will affect not only its members today but many new ones over the next quarter century, the Council directed that a study be carried out entailing generally all the scientific and educational functions of the association, specifically these five:

1. The annual scientific session.
2. Postgraduate courses.
3. The journal, CALIFORNIA MEDICINE.
4. The Cancer Commission.
5. Audio-Digest Foundation.

Should these functions be continued, enlarged, altered, added to, discontinued?

Beyond these specific categories, quite obviously, study of these elements of the Association must extend to their inter-relationship with similar functions of other organizations. It must be recognized, for example, that intelligent inquiry into the diminishing stature of the C.M.A. Annual Scientific Session must take into account such related matters as the growing number of meetings by various specialty organizations that conflict with ours both as to dates and scope of interest. Nor can our postgraduate courses be properly appraised and directed without consideration of similar courses offered by medical schools, by specialty groups, by hospitals, by voluntary health agencies, and, recently, by pharmaceutical houses.

The committee which the Council authorized be appointed to make the study was selected to include physicians who, among them, can bring to the project special information and expert opinion not only as to the availability and worth of various means of education but also as to the sort of facilities most needed.*

Among the many avenues of inquiry related to the study that were developed at the first meeting of the committee were:

- Ways to overcome the "psychological isolation" of physicians practicing in areas remote from centers of medical research and teaching.
- The difference between the postgraduate needs of physicians of different ages and distances from research centers.
- The need for clinically oriented programs and also for a balance of courses between clinical and medico-economic subjects.
- The place of voluntary health agencies and, more recently, pharmaceutical houses, in the programming of postgraduate courses.

*Donald A. Charnock, Los Angeles, a past president of the California Medical Association.
Werner F. Hoyt, Mt. Shasta, Siskiyou County.
William P. Longmire, Jr., Department of Surgery, University of California at Los Angeles School of Medicine.
Clayton G. Loosli, Dean, University of Southern California School of Medicine, Los Angeles.
G. E. Norwood, Assistant Dean and Chairman of the Division of Postgraduate Medicine, College of Medical Evangelists, Los Angeles.
Lowell A. Rantz, Associate Dean, Stanford University School of Medicine, Palo Alto.
John B. de C. M. Saunders, Dean, University of California School of Medicine, San Francisco.
Joseph W. Telford, San Diego, past president of the California Academy of General Practice and now a member of that organization's membership commission.
Dwight L. Wilbur, editor, CALIFORNIA MEDICINE, chairman.

California MEDICAL ASSOCIATION

# NOTICES & REPORTS

## A.M.A. Meeting

**The following summary of actions of the House of Delegates at the American Medical Association's Thirteenth Clinical Meeting, held December 1-4, 1959, in Dallas, is not intended as a detailed report on all actions taken. It has been composited from reports by Mr. Ed Clancy, director of public relations of the California Medical Association, and by Dr. F. J. L. Blasingame, executive vice-president of the American Medical Association.**

FREEDOM OF CHOICE of physician, relations between physicians and hospitals, a scholarship program for deserving medical students and relative value studies of medical services were among the major subjects acted upon by the House of Delegates at the American Medical Association's Thirteenth Clinical Meeting held December 1 to 4 in Dallas.

Of the resolutions introduced to the House, sent to reference committees and reported back at the final session, the policy statement introduced by Dr. Dwight H. Murray, Napa, relative to voluntary health insurance, was perhaps one of the most important to receive unanimous approval.

### REITERATION OF A.M.A. SUPPORT OF BLUE SHIELD CONCEPT

Introduced on behalf of the California, Florida, Michigan, Nebraska, New York and North Dakota delegations, the resolution states:

WHEREAS, The traditional concern of the American Medical Association has been to serve the health needs of the American people; and

WHEREAS, Changes in the economic and social characteristics of the American people have made necessary the development of prepayment mechanisms for assisting in the payment of their medical care costs; and

WHEREAS, This has resulted in the development of a widespread and effective system of voluntary health insurance; and

WHEREAS, Local physicians' sponsored and approved community prepayment medical care plans have become a most effective mechanism in this voluntary system; therefore be it

*Resolved,* That (1) the A.M.A. reiterate its support of the Blue Shield concept; and (2) the Council on Medical Service be directed to prepare and submit to the House of Delegates at the June 1960 meeting its recommendations as to a full statement of policy with respect to the American Medical Association's relationship with Blue Shield plans.

### FREEDOM OF CHOICE

An amendment to the Report of the Reference Committee on Insurance and Medical Services, reaffirmed medicine's position on the importance of freedom of choice of physician "to optimal medical care."

The report stated:

"Lest there be any misunderstanding we state unequivocally that the A.M.A. firmly subscribes to freedom of choice of physician and free competition among physicians as being prerequisites to optimal medical care. The benefits of any system which provides medical care must be judged on the degree to which it allows or abridges such freedom of choice and such competition."

# 3 POSTGRADUATE COURSES

*During*

## C.M.A. ANNUAL SESSION

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*Place:* February 21 at Chapman Park Hotel, February 22 and 23 at Ambassador Hotel, Los Angeles.

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### CLINICAL ENDOCRINOLOGY—9 hours

*Time:* Sunday, Monday and Tuesday, February 21, 22 and 23, 1960—9:00 a.m. to 12:00 noon.

*Place:* February 21 at Los Angeles County Hospital, February 22 and 23 at Ambassador Hotel, Los Angeles.

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---

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# 1960

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  Sunday, February 21 • Wednesday, February 24
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## Tranquilizers Have "Little to Offer" in Skin Conditions

Tranquilizing drugs have "little to offer" in the treatment of patients with dermatological conditions, a Hayward, California, physician found after an extensive study which required four years to complete.

Dr. Wayne Wright, who reported his findings in the *Journal of the American Medical Association*, used nearly every type of tranquilizing drug in a study which involved a total of 740 patients, who were suffering from a wide variety of skin conditions. Many of the clinical cases were from the Travis Air Force Hospital in Fairfield, California.

Dr. Wright, who was assisted in his study by Drs. Jean S. Wright and Max Krause, concluded that there was only one type of dermatological condition which was helped by a tranquilizing drug. Nummular eczema, characterized by coin-shaped patches on the skin, was "definitely benefited" by one of the drugs, hydroxyzine hydrochloride.

Enough patients were helped, Dr. Wright said, to "conclude that it merits a trial in treatment of patients with this condition."

As adjunctive therapy, the tranquilizers help to relieve itching, to produce sleep, and to allow dosage of steroids and certain hormones to be reduced, the *Journal* article said.

The study revealed that the patients suffered many side reactions from this class of drugs whose principal effect is to calm down nervous, anxious, excited and agitated people. Minor side effects of the drugs used were blurred vision, nasal congestion, dryness of the mouth, changes in the pulse rate and constipation. The most serious side reactions were convulsions.

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## 6,860 Students Receive M.D. Degrees in 1958-59

(Continued from Front Advertising Section, Page 49)

sents a challenge at least as important as any problem facing medicine today," the A.M.A. report said.

The council indicated a need for 10,000 graduates a year from medical schools in the United States by 1975.

"The fundamental issue," the report said, "does not involve the question of which of various studies have resulted in the most accurate estimate of the need for increased numbers of medical school graduates. The basic and urgent concern is that all estimates indicate a need for expansion of educational facilities in medicine in a brief period which far exceeds any expansion of such facilities that has occurred in a similar period during modern times."

The council offered several methods which could be used to meet the need for expanded educational

facilities in medicine, including increased capacity of existing medical schools, but then added:

"Care must be exercised that medical schools not be induced to expand beyond their capacity to maintain the proportionately increased teaching staff necessary to preserve high standards of education and research."

The council estimated that even though existing schools are expanded, "it appears likely that at least 10 new schools with an average graduating class of 100 students will be required" to meet the health care needs of an exploding population.

On the subject of medical students of the future, the council said that " medicine is finding increased competition for the pool of top-ranking students because it no longer occupies the unique position as a profession which it held in the past and shared largely only with law and the ministry. The professions open to the college graduate are now much broader, and they provide the prestige, intellectual satisfaction, and financial rewards comparable to those offered by medicine."

The council cautioned that "medicine must make active efforts to inform young people of the breadth of interests and challenges it offers or surely it will suffer a serious loss of the best young talent."

Other salient points in the council's report are:

—During 1958-59, 56 institutions in the U. S. and five in Canada initiated, completed or have funds committed for construction and equipment of new facilities.

—Major projects planned for initiation in 1959-60, with funds already committed, are estimated at approximately 49 million dollars for construction and five million dollars for equipment. Such construction is being planned by 31 schools.

—The total enrollment in first year medical school classes for the 1958-59 academic year was 8,128, the largest to date in the United States. Entering class sizes increased in 35 schools, were unchanged in 24 and decreased in 26.

—In 1958-59, a total of 59,102 applications were filed by 15,170 persons or an average of 3.9 applications made by each prospective medical student.

—Of all first-year medical students, more than one-third, 37 per cent, came from five states—New York, Pennsylvania, California, Ohio, and Illinois.

—There were fewer than 20 first-year medical students from each of seven states—Alaska, Delaware, Maine, Nevada, New Mexico, Vermont, and Wyoming, and fewer than 30 from two other states—New Hampshire and Rhode Island. Of these nine states, only New Hampshire and Vermont have medical schools.

—At least two-thirds of the entering classes comprise "B" average students. About one-sixth had college grade averages of "A" and about one-sixth to one-seventh had "C" averages.

## "Cluster Headache" Called Type of Migraine

Repeated daily attacks of migraine headache are actually a specific type of migraine—"cluster headache." Also called "Harris's migraine" after the man who first systematically described the condition, "cluster headache" occurs after weeks of freedom from pain. A bout usually lasts for weeks, with the patient having at least one attack daily.

Other characteristics of the condition, as described in an editorial in the October 31 issue of the *Journal of the American Medical Association*, are:

—The patient is more often a man than a woman (between two and four to one) and between the ages of 30 and 50 years, although first attacks have been reported in patients as young as 11 and as old as 59.

—The attacks of pain are intolerable, but their duration is relatively short—minutes to an hour. The constant boring or throbbing pain is at the outer side of the eye. It may spread to the remainder of the cheek, the forehead, the scalp and occasionally, the neck.

—The pain usually affects the same side repeatedly, in fact, the same spot. Most attacks occur on the right side.

—In contrast to the more usual migraine where the patient prefers to lie down and pull the covers over his head, with cluster headaches, he cannot recline and usually must pace. There seems to be a relationship between the pain and the muscular activity that it causes.

—The attacks tend to occur at the same time of day or night, most frequently between 2 and 3 a.m.

—The bouts recur irregularly and then may cease after occuring for years.

—Most patients have previously had the more classic form of migraine, which is replaced by the Harris form.

Preventive treatment consists of regular injections of ergotamine tartrate, a drug commonly used in oral form for the treatment of regular migraine. The patient is taught to give himself the injections daily for five days in each week. The two free days allow the patient to determine whether the bout of pain has ceased.

Another interesting fact about this "variant of the galaxy that is migraine" is that the patient cannot tolerate alcoholic drinks during a bout, presumably because of the alcohol's dilating effect on the blood vessels of the head.

---

## Oral Polio Vaccine Safety Questioned

The risks of oral polio vaccine "appear to be greater than had been suspected" and much more knowledge must be obtained before it can be considered safe.

Vaccines made from live polio viruses reduced in strength are now being given by mouth to thousands of children all over the world, under the direction of Dr. Albert Sabin, University of Cincinnati, developer of the vaccine.

The researchers, Joseph L. Melnick, Ph.D., Matilda Benyesh-Melnick, M.D., and James C. Brennan, M.D., said, "If caution was called for in 1954 and 1955 when the Salk vaccine was introduced into large-scale field use, then caution should also be the watchword now."

The safety of the vaccine has not been definitely proved. Safety tests performed in a number of different laboratories are in "serious disagreement" about the degree of attenuation (reduction in strength) of the viruses.

"We do not imply that we have proved that such virus strains are dangerous either for the vaccinated child or for the community, but we wish to emphasize that the risks appear to be greater than had been suspected and that much more knowledge must be obtained . . . before the available attenuated strains can be said to meet the criteria of a safe and effective vaccine. . . ."

A study among Mexican children showed many who were free of polio antibody, but who failed to develop antibodies when given the vaccine. This apparently occurred because they were already infected with a nonpolio enterovirus and this infection blocked the implantation of the polio virus. Such interference might well limit the effectiveness of an orally given vaccine in areas where enterovirus infections are common.

In addition, the Mexico City study showed that the number of children with polio antibodies prior to receiving vaccine was already 33 per cent among one-year-old children; 54 per cent in two-year-olds, and 85 per cent in three-to-five-year-olds.

Giving vaccine to children whose contacts are chiefly immune by natural infections tells very little about the safety of a vaccine for a community, since the opportunities of spread in an immune population are severely limited. Thus the vaccine must be tried in groups with low rates of immunity. Then it can be determined if a spread of the virus from vaccinated to non-vaccinated individuals is dangerous, the authors said.

The question of safety resolves itself on the frequency of disease in vaccinated children and their contacts, as compared with that anticipated from natural infection, they concluded.

The authors are with the department of virology and epidemiology and the department of pathology at Baylor University College of Medicine.

## The Surgical Conscience*

Conscience in surgery means a strong sense of right and wrong, a willingness to help others, a feeling of compassion for the unfortunate, self-discipline, and a strong faith in the sanctity of God and man. It can be conditioned by education and experience. It depends not only on the surgeon's individual moral fiber and religious concepts, but also on his heritage of philosophical doctrines, his scientific and factual knowledge, and his judgment. It determines his conduct in many situations, such as the current difficulty with hospital-acquired infections, where temporary individual gains from the misuse of antibiotics may result in protracted trouble to a community. It compels the surgeon at times to resist popular demands and to have the moral courage to protest. It requires him to rise above the selfishness of small professional groups and to devote himself to the individual patient with gentleness, compassion, firmness, and resolution. Many of the current problems concerning the care of the sick are complicated, not solved, by rigid regulations and dictatorial authority. Their solution depends, rather, on a rebirth of the surgical conscience.

*Abstract from A.M.A. Arch. Surg., 79:167-175, Aug. 1959, W. A. Altemeier.

## Progress of Medical Science Forces High Laboratory Cost

How the progress of medical science forces the cost of certain laboratory procedures to reach almost unrealistic levels over which neither patient nor physician has control is seen from an article appearing in the *Journal of the American Medical Association.*

Heart catheterization, a valuable diagnostic tool to the physician, has grown exceedingly complex and costly, especially in relation to the equipment and personnel required. This cost, however, is only the beginning. Heart catheterization is one of many procedures terminating in cardiac surgery which is carried out by a large team using a costly heart pump.

Cost analysis of heart catheterization is covered in a *Journal* article written by Dr. Max H. Weil, formerly chief of cardiology at the City of Hope Medical Center, Duarte, California, and presently assistant professor of medicine at the University of Southern California School of Medicine, Los Angeles.

Heart catheterization, first described by Dr. Werner Forssmann of West Germany in 1929, is used as a diagnostic procedure in certain types of heart conditions, especialy in children born with heart defects. In 1956, Dr. Forssmann, along with Drs. Andre F. Cournand and Dickinson W. Richards of Columbia University, were jointly awarded the Nobel prize in medicine for perfecting a method of charting the human heart by catheterization.

The technique, for example, can yield valuable data on the pressure and oxygen content of the blood and the way in which the blood flows through the pulmonary artery system, and the contributing systemic circuit. Since definitive treatment of congenital heart lesions is surgical, the information obtained by cardiac catheterization is sometimes needed in order to reduce the number of patients

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## CLASSIFIED ADVERTISEMENTS

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## Accidental Poisoning Cases Are on the Increase

An official of the New York City Department of Health termed as "alarming" the increasing number of fatalities from accidental poisonings.

Dr. Harold Jacobziner, assistant commissioner of the department, called for a broad educational campaign to alert the nation to the dangers of poisoning from drugs and household products.

Writing in the *Journal of the American Medical Association,* Dr. Jacobziner said, "Fourteen hundred fifty deaths were reported in the United States last year from poisonings by agents other than poison gases and spoiled food. Over 400 of these deaths were in children under five years of age.

"More children under five . . . died last year in New York City from accidental chemical poisonings than from diphtheria, poliomyelitis, rheumatic fever, scarlet fever, and other streptococcic infections combined.

"The alarming increase in both fatal and nonfatal poisonings is related to the rise in new products and to the increase in the population risk."

The doctor said that "internally taken drugs caused nearly 50 per cent of all poisonings, with barbiturates and aspirin as the chief offenders. Next in frequency were poisonings due to household preparations followed by those with externally applied drugs and cosmetics, pesticides, and miscellaneous products such as lead."

In offering a solution to cut down on the number of such accidents, Dr. Jacobziner said that nearly all poisonings are preventable.

"The most important item in prevention is knowledge and information about the risk involved and the population risk. Regulations and labeling alone will not prevent accidental poisonings but must be coupled with education."

He urged that such an educational program be based on facts, accurate, reliable, devoid of overdramatization, simply told, and pinpointed to the vulnerable groups and the specific hazards.

Key points in such a program, the doctor continued, should include strong emphasis on the need for keeping medications in their original containers and also for keeping all drugs and preparations out of reach of children.

He said that proper labeling of toxic substances, as recommended by the American Medical Association Committee on Toxicology, is exceedingly important. These recommendations are embodied in H. R. 7352 which was introduced in Congress by Representative Thomas B. Curtis (R-Mo.) and is pending before the House Interstate Commerce Committee.

In concluding, Dr. Jacobziner said, "Prevention is possible through education at all levels. Education requires an integrated team approach with the family physician as key member of the team. Accident prevention . . . merits the greater attention and involvement of the practicing physician."

## Progress of Medical Science Forces High Laboratory Cost

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undergoing surgery for inoperable defects or denied operation for defects that could be corrected.

Dr. Weil stated that while the procedure is valuable in many respects, "the financial burden of development and maintenance of a proficient cardiac catheterization laboratory is such that the unit can hardly be self-sufficient."

"In addition to the need of costly physical space in a hospital area, the expense of special installation in a properly equipped laboratory may be in excess of $100,000," he said. He provided a detailed summary of actual costs involved in the establishment of one such unit. It ran to $104,113.88.

He said that with so many remarkable refinements taking place constantly in cardiac catheterization, the equipment requires almost constant replacement. It is estimated that the basic expenditure will be repeated at the end of five years.

"Further," Dr. Weil said, "successful conduct of the laboratory requires a competent medical staff on at least a half-time basis." Each procedure requires participation of a minimum of two physicians, a nurse and three additional trained persons. In small children, the services of a highly skilled anesthesiologist are required.

If three cardiac catheterizations are done weekly, the cost of technical and nursing personnel alone for each procedure is $130. This does not include the fee for the cardiologist's services or for anesthesia.

"Then expendable items such as catheters, x-ray film, radiopaque mediums and recording paper add about $65 for each procedure," he said.

Dr. Weil also pointed out that the paper work and study of data in connection with each procedure are enormous. A typical case involving the procedure—interpretation of data, calculations and compilation of the report—requires a minimum of eight hours of a heart specialist's time alone.

Dr. Weil offered a solution to the complex cost problem.

"Would it not be far better," he asked, "to pool professional and financial resources and thereby provide generous support of a centralized laboratory? Cardiac clinics throughout a geographical area, each of which has but a limited number of patients requiring detailed studies, would share the advantages provided by a laboratory which is more adequately staffed and equipped."